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Pejorative Phrases or Innocent Idioms? Exploring terms used by Tomorrow's Doctors in relation to Older People

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ABSTRACT

Older people are 'core business' for 21st century hospitals. Of concern therefore, is negative stereotyping of older people by medical students. Through a bespoke teaching session for final year medical students, we aimed to deconstruct the phraseology they employed in relation to older people and to drive attitudinal change amongst students. This study also aimed to discern whether there was a detectable difference in attitudes towards older people after the session. Forty-seven medical students participated. Students recorded in a 'word-cloud' terms they associated with older people in hospital before and after the session. The University of California Los Angeles Geriatrics Attitude Scale was administered pre-session. The intervention students, along with a control group, completed this instrument at the end of their placement. Content analysis of word cloud data was performed - an iterative, transparent, structured approach to analysis, along with external critique of findings and collaborative triangulation, ensured rigour of analysis. Qualitative analysis demonstrated the use of pejorative and sometimes nihilistic terms. There was evidence of growing appreciation of the inherent complexity of caring for older people and increasing awareness of how healthcare systems can be challenging for older people. Quantitative analysis revealed no statistical difference between the UCLA-GAS pre- and post-teaching, nor between intervention and control groups. In conclusion, a bespoke educational intervention, designed to promote student reflection on their views towards older people in hospital, can be a catalyst to challenging superficial and stereotypical views.

INTRODUCTION

The United Kingdom's population is aging (Office for National Statistics 2012) – already older people can be considered 'core business' for the National Health Service (Oliver, Foot, & Humphries, 2014). The recent high-profile Francis Inquiry (2013) and Keogh Report (2013) demonstrated many severe deficiencies in care, particularly for older people. Poor attitudes towards older people, both at an individual level and organizational level, were identified as contributory towards sub-standard care. It is recognised that negative stereotypes of older patients persist amongst medical students (Samra et al, 2015). The language used by health professionals when referring to older people is of critical importance. Language represents an expression of the beliefs one may hold, teaches others what is socially acceptable to say, reinforces common cultural beliefs and is the foundation of a medical meme. For example, many geriatricians perceive oft heard expressions such as 'acopia', 'bed blocker' and 'poor historian' to be pejorative (Fisher, 2016; Kee & Rippingale, 2009; Oliver, 2008) – the use of which may, unwittingly, become a barrier to quality care and reinforce negative stereotyping. This assertion is supported by the fact that some scientific journals have issued specific guidance on how older people ought to be referred to (Lundebjerg, Trucil, Hammond, & Applegate, 2017).

Using a custom-designed teaching intervention for final year medical students, this project aimed to determine the impact on medical students of a teaching session that challenges the use of terms relating to older people that may be considered pejorative. There were two specific enquiry objectives: 1) to deconstruct the language and phraseology used by medical students when referring to older people; 2) to discern whether there is a detectable difference in medical student

'attitudes' towards older people after a targeted teaching session. We considered 'attitudes' to be the preconceptions held, and the associations made, by medical students about older people.

METHODS

Study Participants

Participants were final year undergraduate students at a UK medical school. The teaching intervention formed part of the final year 8-week Hospital Based Practice (HBP) module at this site. 'Control' students, undertaking the same module, but not the teaching intervention, were recruited from a geographically discrete site. Ethical approval was obtained from Newcastle University's School of Medical Education Research Management Group and the university's ethics committee. All students provided informed consent for participation.

The Teaching Intervention

Students were divided into three groups and the teaching intervention ran on three separate occasions. The 210 minute session was structured around three interactive stations: 'poor historian', 'off legs/mechanical fall', 'acopia'.

Introductory Plenary

Students participated in an introductory session during which they were divided into smaller groups. Students stayed in these groups for the remainder of the session. This session was used for preliminary data collection before the students moved to interactive stations. Once this task

was complete students moved into the interactive stations – each lasted for 45 minutes and was structured as follows:

'Poor Historian'

This station drew on previously recorded video footage of clinical interactions between a teaching fellow and patients. In each interaction, history-taking was challenging. After the first video had been played, a semi-structured discussion ensued; students were asked to consider whether the patient was a 'poor historian'. The aim of this station was to engender amongst students the need to seek to 'diagnose' the reason for the communication problem (Coulehan & Block, 2006), rather than to neglect this thought process through the application of the 'poor historian' label. Subsequent videos provided students with the opportunity to hunt for the hidden diagnoses behind the 'poor historian' label and included: speech disturbance (dysphasia and dysarthria), profound hearing impairment, prominent regional accents, and profound emotional distress.

'Off Legs/Mechanical fall'

Students were asked to assess a patient with advanced dementia, represented by a simulation mannequin, who had been admitted from their nursing home having been found on the floor (Fisher, Rudd, Walker, & Stewart, 2016). The patient was described as 'off legs' and as having had a 'mechanical fall'. The hidden, underlying diagnosis in this station was elder abuse. The challenge for students was to look past the assumptions about the nature of the 'fall', as a series of suspicious injuries were identifiable if students completed a thorough examination. The

station concluded with a debrief where students had the opportunity to reflect on their success, or in some instances failure, in recognising elder abuse. Discussion considered the language used in the referral letter and what potential impact this had upon students' diagnostic reasoning.

'Acopia'

This station began with a case-based discussion of a patient 'diagnosed' with 'acopia' – students were asked to consider what this term meant, and when and why it might be employed. Students were then asked to critically appraise a retrospective study of patients initially labelled as 'acopia' at presentation that explored their clinical characteristics, eventual diagnoses and health outcomes (Kee & Rippingale, 2009). The aim of this session was to demonstrate the high prevalence of acute medical problems within this cohort and the high associated mortality rate.

Data Collection and Analysis

Two methods of data collection were employed:

1. Recording student nomenclature through 'word clouds'

During the introductory plenary students, in small groups, were asked to record on A0 paper in black ink, words or phrases they "associate with older people in hospital". After completion of the stations, students returned to the plenary room for a round-up session. The same small groups were reconvened and were given their original A0 paper along with red-ink pens. They were then

invited to: add additional words or phrases that they now associated with older people; make any amendments they wished to words or phrases they previously recorded; score out any words or phrases that were no longer pertinent or applicable. After this was complete the sheets were collected by the research team. This approach to data collection enabled both the first and second enquiry objectives to be addressed.

2. University of California, Los Angeles Geriatrics Attitude Scale (UCLA-GAS)

The UCLA-GAS, a validated instrument for measuring attitudes towards older people (Reuben et al, 1998), was employed to gather quantitative data and to address the second enquiry objective. The UCLA-GAS is a 14-item questionnaire with a mixture of positively and negatively worded questions. Minor amendments were made to the phrasing to align with local United Kingdom (UK) terminology - "federal government" became "government" and "Medicare" became "care of the elderly". Responses are recorded on a 5-point Likert scale that ranges from strongly disagree to strongly agree. Scores for negatively worded statements are reversed to allow comparisons. In-keeping with previous research employing the UCLA-GAS (Lindberg & Sullivan, 1996), scores were added and the mean score across all UCLA-GAS items was calculated for each student.

Students who received the teaching intervention completed the UCLA-GAS on two occasions: during the introductory plenary and during the final week of their HBP module four weeks later. Students provided their individual student numbers on response sheets, enabling their responses

to be matched over time. The UCLA-GAS was also completed by control students during the final week of their HBP module. Both groups were working towards the same learning outcomes, so this approach enabled comparison to be drawn between an intervention and a 'control' group.

Data analysis

The qualitative data analysis was used to answer the first and second inquiry objectives. All words and phrases captured were transcribed, distinguishing between 'before' and 'after' by replicating the ink colours used. The first sort of the data was by Simple Content Analysis (JS) where identical or equivalent words were grouped together and counted. Grouped words were placed under three overarching data categories (Table 1).

In the second sort, similar topics were grouped together and labelled (Tables 2-4). Re-shuffling and re-sorting took place as labels became redundant and others emerged. These processes helped develop our understanding of the terms and phrases employed by medical students in relation to older people.

Once data sorting was completed, each section was reviewed and meaning construed (Tables 2-4). This process reflects a shift from simply reporting data to its interpretation and was undertaken to help the final stage of analysis and to gauge what impact the session had on students.

A second researcher (JF) independently reviewed each analysis step, checking for appropriateness of groupings and offering alternate interpretations. Differences were discussed

and adjustments made. At the end of the analyses a third researcher (ET), who had not been involved in the data collection or analysis, sense checked the analysis and offered critical review of the interpretation. The third researcher was asked to perform three tasks. First, they were asked to review the sorting of the data and to comment on, support or challenge the sorting under the categories / descriptors. Second, they were asked to write down their key 'take-home' messages from the analysis – these were intended to be global statements about their interpretation of the data in relation to the first enquiry objective. Finally, they were asked to comment on the data from the perspective of the second enquiry objective. The output of this independent analysis was collated in a written document and was reviewed at a meeting of the three researchers. Refinement of analysis and further discussion continued in an iterative fashion until consensus was achieved.

For quantitative data, the independent t-test was used to examine for differences between intervention and control cohorts' mean UCLA-GAS scores in the post-test assessment. The paired t-test was used to examine for differences between mean UCLA-GAS scores within the intervention cohort after repeat assessments. Mean UCLA-GAS scores were normally distributed parametric data, hence the test selection. Significance was defined as $p<0.05$.

RESULTS

47 students participated; all completed the pre-intervention UCLA-GAS. 37 (78%) completed the post-intervention UCLA-GAS. 49 'controls' completed the UCLA-GAS. Distribution of mean UCLA-GAS scores for intervention students pre- and post-session, along with control

students are shown in Figure 1. Mean UCLA-GAS score for the intervention group was 3.86 (SD=0.38) pre-session and 3.83 (SD=0.48) after. There was no significant difference between pre- and post-intervention scores (p=0.603). Mean UCLA-GAS score for the control group was 3.92 (SD=0.31). No significant difference in mean UCLA-GAS score was seen between intervention and control groups (p=0.261).

The results of the qualitative analysis generated three overarching categories within analysis of student text data. Table 1 provides an overview of these data categories, their sub-categories and, for each sub-category, a descriptor that outlines the nature of that sub-category. The terms employed by students and the sub-category to which each term was deemed to belong, are displayed in Table 2 (Medical features relating to older people), Table 3 (Care features relating to older people) and Table 4 (Social and personal features relating to older people). Text that was added after the teaching intervention is depicted by capitalised, italicised, underlined text. Text that was subsequently deleted by students is depicted with 'strikethrough'. The number of times the term was used is included in brackets following the text. All text is reproduced exactly as written by students.

DISCUSSION

The aim of this study was to deconstruct the phraseology used by medical students when referring to older people, and to discern whether there was a detectable difference in medical students' attitudes towards older people after a targeted teaching session. With regards the quantitative application of the UCLA-GAS, there was no significant change in students' mean

scores following the teaching intervention. Neither was there a difference between the mean scores of the intervention and control group at the end of their HBP module. It is either possible that the teaching intervention had no impact on students' attitudes, or that the UCLA-GAS failed to reflect a change. The incomplete response rate post-session and potential confounding impact of the remainder of the HBP rotation make drawing meaningful conclusions challenging. Of note, students' UCLA-GAS scores were comparable to previous studies undertaken in the US (De Biasco, Parkas, & Soriano, 2016; Krain, Fitzgerald, Halter, & Williams, 2007)

A recently published review highlighted flaws inherent to all currently available instruments for measuring medical student attitudes towards older people, including the UCLA-GAS (Wilson, Kurrle, & Wilson, 2018). This article called for quantitative studies to be complemented by qualitative data to more fully inform educators in geriatric medicine. Attitudes are complex, multi-faceted phenomena and represent personalised constructs - our use of an alternative, qualitative analytical approach enabled the impact of the teaching intervention to be explored from this perspective. The rigour of the approach was maintained through a series of steps that included: the application of a logical, structured approach to the analytical process, regular meetings between researchers that enabled the analysis process to be discussed and debated to ensure reflexivity, external critique of findings, collaborative triangulation (Tobin & Begley, 2004) as well as transparency of the analysis process. Analysis of student word clouds did suggest a change in the terminology students chose to associate with older people. Following the intervention, students added words and phrases reflecting an awareness of concepts that were previously unfamiliar, for example "elder abuse" and "deprivation of liberty safeguards". Perhaps more significantly, students chose to delete or adapt terms that they had earlier

associated with older people in hospital. This may merely signal a perceived need to adapt their responses to one that is thought more socially desirable or a deliberate rejection of "politically incorrect" terms but with little change in underlying views. However, the ways in which nomenclature was changed, appears to demonstrate a growing appreciation of the inherent complexity of caring for older people.

Evidence of student understanding of complexity emerged in several ways. With regards to the pathology and diagnoses associated with older people, after the teaching session students added terms such as "hidden pathology", "diagnostic conundrums" and "atypical presentation" rather than the typical diagnostic taxonomy, such as "fractured neck of femur". In contrast, references to "acopia" were largely, but not completely, deleted. Most notably, changes in several coding categories alluded to a change in students' views as to their own professional responsibilities. Amongst the "characteristics of communication", "special issues" and "features of old age" sub-categories were changes in terminology, which may demonstrate a growing awareness of their own obligations as a healthcare professional to take ownership of the complexity arising when caring for older people. In contrast to the initial picture of older people themselves as "challenging", the shifts in terminology appear to reflect a change in perceptions towards the healthcare system being "challenging" to older people. Inherent in this change is awareness that it is the professional responsibility of healthcare professionals to find ways around institutional barriers. The finding that this session helped drive this transition amongst students is important, since failure to take 'ownership' for older patients, particularly those with cognitive impairment, has been identified as a barrier to good care (Teodorczuk, Mukaetova-Ladinska, Corbett, & Welfare, 2013).

A notable finding was the use of pejorative language in relation to older people – this included the downright offensive ("dumb"; "wee smell"), the potentially patronising ("cute", "sweet") and examples of crude stereotyping. Interestingly, the students appeared willing to share these terms despite being in a professional setting under supervision from senior colleagues. Whilst the use of these terms is concerning, these findings are in keeping with existing literature that has identified similar views amongst medical students[5,20,21].

Our work helps build a picture of how medical students perceive older people in hospital. The students' construct of these people was somewhat homogeneous and nihilistic ("dependant", "despair", "lonely") and there was only limited use of language with positive sentiment. To tackle these negative stereotypes, it may be helpful to provide students with opportunities for longitudinal follow up with older people after discharge from hospital[22]; seeing older people who have recovered from their illness and have returned to live in the community may help to challenge negative constructs and reframe unhelpful perceptions of older people.

We acknowledge that observed changes in written terminology may not necessarily translate into changes in the language that students use in practice. The relationship between attitudes, intentions and behaviours in clinical practice is long-debated[23]. Whilst it is generally agreed that attitudes have some predictive effect on behaviour, the relationship is also influenced by concepts such as perceived behavioural control, subjective norms and external environmental influences[24]. Even the most admirable attitudes and sincere intentions to provide appropriate care for patients, may be hindered by environmental constraints. For students, there is also the risk that nascent positive attitudes are eroded through poor role modelling from others, particularly

from those in senior positions[25]. Understanding how attitudes to older people are moulded and formed as students transition into working environments and teams is a ripe area for research – future work might consider employing ethnographic methodology to enable deeper exploration. The gap between attitudes and behaviours in medical students means that educators cannot rely solely on class-room based interventions, even if they prove to have impact, to advance the ability of students to care for older people in practice. Interventions that prompt students to reflect on their professional responsibilities towards older patients must be complemented by support for students to embrace and work through complex and ethically charged clinical situations. Without such support and guidance from experienced healthcare professionals, there is the risk that students default back to dismissing patients in frustration as just another case of "acopia" or "off legs".

CONCLUSION

This study offers unique insight into the specific language and phraseology used by medical students when referring to older people. It provides evidence that a bespoke educational intervention, designed to promote student reflection on their views towards older people in hospital, can be a catalyst to challenging superficial and stereotypical views. Quantitative analysis however did not demonstrate a significant cohort change following this teaching initiative. We assert that these findings also serve to highlight the value of utilising more subtle means to consider how educational interventions may impact upon students' attitudes, given their complex, multifaceted nature.

We contend that this type of educational event, late within the students' undergraduate training, gave students opportunities to reframe their identification of and experiences with older people. It also allowed experienced educators to question and challenge discourses that may be pervasive within hospital practice. Integration of such education at an earlier stage in the undergraduate programme (i.e. before beliefs become entrenched) and facilitated longitudinal follow up of 'well' older people, may go some way to broaden students' perceptions of aging and older people.

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Author contributions:

As follows: study concept and design (JF, ET, JS), acquisition of subjects and/or data (JF), analysis and interpretation of data (JF, ET, JS), and preparation of manuscript (JF, ET, JS).

Sponsor's Role:

The study's sponsor (Northumbria Healthcare NHS Foundation Trust) had no direct influence on design, methods, subject recruitment, data collections, analysis or preparation of the paper

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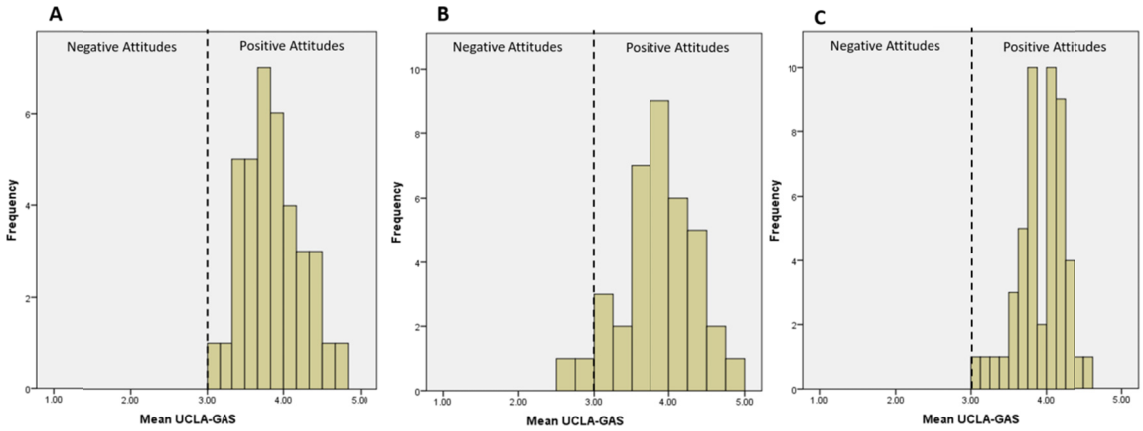
Figure1



Distribution of University of California at Los Angeles Geriatrics Attitudes (UCLA-GAS) for: A - Intervention students pre-session; B - Intervention students post-session; C - Control students

Distribution of University of California at Los Angeles Geriatrics Attitudes (UCLA-GAS) for: (A) Intervention students pre-session, (B) Intervention students post-session, (C) Control students.

Table 1: Overview of Data Categories

MEDICAL FEATURES RELATING TO OLDER PEOPLE	
Sub-category	**Descriptor**
Presentation	Presenting symptoms or syndromes associated with older people
Cognitive Presentations	Medicalization of mental states in older people
The Nature of History Taking	The history taking process from the perspective of the clinician and descriptive of the patient
Diagnostic Challenges	Specific challenges associated with the diagnostic process
Diagnoses	Medical diagnoses commonly associated with older people commonly present to acute care
Characteristics of Communication	Features of communicating with older people and the skills clinicians require
Characteristics of Mobility	The features and challenges of older people mobility

Management Challenges	Specific challenges associated with medication and treatment of older people
Associated Treatments	Treatments associated with older people
CARE FEATURES RELATING TO OLDER PEOPLE	
Sub-category	**Descriptor**
Structures associated with Care	Care structures, plans and environments associated with the management of older people
Being treated as old	The issues associated with being an 'older' patient
Support	Health professional roles, support *and care* systems associated with older people
Aids	Equipment associated with older people
Governance	The legislative and legal frameworks supporting the care of older people

SOCIAL AND PERSONAL FEATURES RELATING TO OLDER PEOPLE	
Sub-category	**Descriptor**
Being old	Value-laden, non-medical features to describe older people
Social states	Social circumstances associated with older people
Artefacts	Stereotypical artefacts associated with older people

Table 2: Medical Features Relating to Older People*

Presentations	***Cognitive Presentations***	***The Nature of History Taking***	***Diagnoses***	***Characteristics of Mobility***	***Associated Treatments***	***Characteristics of Communication***	***Management Challenges***	***Diagnostic challenges***
Co-morbidity (7); Multi-factorial (1)	Confused (12); Confusion (1)	Collateral hX (1); Collateral Hx – detective (1)	Pneumonia (2); Aspiration (1); UTI (3); *SEPSIS (1)*	Fall(s) (12); Fallers (1); Falls risk (1)	Senna (2); Docusate (1); Enema (1); Movicol (1)	Deaf (6); Hard of hearing (4); *HEARING IMPAIRMENT (1)*	Polypharmacy (5); Lots of medication (1)	*MISDIAGNOSED (1)*
Frail (8)	Cognitive	Hard history	COPD (1)	Slippers (falls	Warfarin (1)	Stories (2); Interesting	Impossible to	*DIAGNOSTIC*

	impairment (1)	(1); ~~Hard~~ *CHALLENGING* history (1)		risk) (1)		stories (1); Reminiscent (1)	cannulate (1)	*CONUNDRUMS (1)*
Chronic disease (2); Chronic (1); Chronic pain (1); *CHRONIC (1);*	Delirious (2); Deliriu m (8); Delirious (sometimes) (1); DELERIUM (1); ~~*CONFUSED*~~ = *DELE*	*DIAGNOSE AND FIX DIFFICULTY ELICITING HISTORY – NOT POOR HISTORIAN (1)*	NOF (1); #NOF (4); Ensure #NOF (1); Broken hips (1); Osteoporosis (2)	Immobile (1); Immobility (1); Walking problems (1)	~~*CATHETER*~~ (1)	*MAY REQUIRE DIFFERENT COMMUNICATION STYLES / TECHNIQUES (1); DIFFERENT COMMUNICATION METHODS (1)*	Complex cases (1); Complicated (3)*; COMPLEX CARE (1); COMPLEX (3)*	

	RIUM (1)							
Malnourished (1); Malnutrition (1)	Senile (1)	~~*POOR HISTORIAN (1);*~~ *POOR HISTORIAN (2)*	Postural hypotension (1)	Mobility (1)		Talkative (2); Talkers (1)		
Unstable (1); Off legs (1); ~~*OFF LEGS*~~ (1); Dizzy (1)	Disorientated (1)		Subarachnoid Haemorrhage (1); *STROKE (2)*	A of 1 / 2 (1)		*DIFFICULT COMMUNICATION (1); COMMUNICATIVE IMPAREMENT (1)*		
Constipated (2);	Depression (2)		MRSA (1); C			*COMMUNICATION*		

Incontinent (~~DOUBLE~~) (1); Incontinence (3)			Diff (1); Pressure sores (1)			*SKILLS (1); COMMUNICATION (2)*		
'Acopia' (1); ~~ACOPIA~~ (4); *ACOPIA* (2); *NOT ACOPIA*!! (1)	Dementia (6); Demented (1); *DEMENTIA (4)*					*SLOW (SPEECH) (1)*		
UNDERLYING PATHOLOGY (1); HIDDEN PATHOL								

OGY (1)								
(INCREASED) MEDICAL PROBLEMS (1)								
ATYPICAL PRESENTATION (1)								
UNSAFE SWALLOW (1); DYSPHASIA (5); APHASIA /								

DYSPHASIA (1)								

**Text that was added after the teaching intervention is depicted by capitalised, italicised, underlined text. Text that was subsequently deleted by students is depicted with 'strikethrough'. The number of times the term was used is included in brackets following the text. All text is reproduced exactly as it was written by students.*

Table 3: Care Features Relating to Older People*****

Structures associated with Care	***Being treated as 'old'***	***Support***	***Medical Equipment***	***Governance***
H2h (3)	Ignored (2); *IGNORED (3)*	Geriatrics / COTE (1)	Glasses (5)	DNACPR (3); cDNACPR (1)
Care packages (2)	*LABELLED (1); UNFAIRLY LABELLED (1)*	MDT (3); *Multi-disciplinary Team (1)*	Dentures (3)	*DNAR!!* (1)
Social Care (1); Social care needs	*STEREOTYPING (1); STEREOTYPED*	Social Worker (1)	Stick (1)	IMCA (Independent Medical Capacity

(1); Care plans (1)	*(1)*			Advocate) (1)
Discharge planning (1)	*DIFFERENT AGENDA (1)*	Nutritionist (1)	Zimmer (1); Aof2 with Zimmer (1)	TEP (Treatment Escalation Plan)(2)
MUST Score (1)	*CONTEXT DEPENDENT (1); ADJUSTMENTS (1)*	*OT (*1)	Hoist – ARJO (1)	Capacity (1); *CAPACITY (2)*
Palliative care (1); Palliative (1); Palliation (1); End of life care (2); Death / Palliative (1)	*NEGLECTED (2); NEGLECT (1)*	SALT (1); *SALT* (1)	Commode (1)	*ADRT (1)*
Nursing home (1);	*NOT GIVEN ENOUGH TIME (1);*	Carer (1); Carer support (1);	Hearing Aids (3); *HEARING*	*DOLS (7)*

NURSING CARE (1)	*DISMISSED (1)*	*CARER* (1)	*AIDS (1); HEARING AID (ATTACHED TO DEAF) (1)*	
Care homes (1); *CARE HOMES (1)*	*MISUNDERSTOOD (3)*	Annoying relatives (1); ~~Annoying~~ *CONCERNED* relatives (1)		*POWER OF ATTORNEY (2); SAFEGUARDING (1*)
Social care (1); Social work/ care (1); Rehab (2); PCU (1); Home Situation (1); Long stay (1)	*MISTREATED (1)*			
	STIGMATISED (1)			

	OFTEN *PATRONISED (1)*			

Text that was added after the teaching intervention is depicted by capitalised, italicised, underlined text. Text that was subsequently deleted by students is depicted with 'strikethrough'. The number of times the term was used is included in brackets following the text. All text is reproduced exactly as it was written by students.*Table 4. Social and Personal Features Relating to Older People***

Being old	**Being old [continued]**	**Social states**	**Artefacts**
Crap environment – scared, deaf/ dumb; multiple pathology, confused, frail, difficult, incontinent (1)	Dignity (2); *DIGNITY (2)*	Dependent (4)	Chocolate + boiled sweets (1)
Ill (2); Fragile (1); Slow (5); Old (2); Weak (1)	Young at heart (1); "good for 80" (1)	Striving for independence (1)	Werther's Originals (2); *WERTHER'S ORIGINALS (2)*
Wrinkly (1); Grey (1)	Fun (1) Funny (2)	(Not) coping at home (1);	Tea (1); Biscuits (1)

		Don't want to be in hospital (1)	
Appreciative (5); Grateful (2); Grateful to everyone involved in care (1); *THANKFUL* (1)	Challenging (1); *CHALLENGING (1)*	Quality of life (2)	Marbles (1)
Lovely (1); Lovely; respectly; kind; grateful (1); *LOVELY [v replaces the n in 'lonely' (1)*	Knowledgeable (1); Wise (1); Interesting (5)	Social circumstances (1)	War (1)
Sweet (4); Cute (4); Kind (2); Smiles (1); Pleasant (1); *NICE (1); FRIENDLY* (1)	Flirt (1); Disinhibited (1)	Partners which require full time care (1)	Cap (1)
Not wanting to be a burden (1); Tolerance (1) Stoical (3)	Lost (1); Burden (1)	Family (1); Significant others / family (1); *FAMILY* (1)	*DEREK* (1)
Wee smell (1); Smell (2) Smell*Y* (1); ~~*SMELL*~~ (1)	Sad (1) Sadness (1); Despair (1)	Grandparents (1)	

Vulnerable to abuse (1); Vulnerable (3); Vulnerable to infection (1); *VULNERABLE (6); MAY BE VULNERABLE (1); AT RISK (1); ABUSE(D) (8)*	Habitual (1); Bored (1); Common (1)	Dependents (1)	
Deterioration (1); On their way out (1); ~~On their way out~~ *(SCORED OUT) (*1) Death (3); *BEREAVEMENT (1); GRIEF + BEREAVEMENT (1)*	Determined (1); Resilient (1)	Lonely (9); Loneliness (1); *LONELY (1); ISOLATION (1)*	
	Caring (1); *CARING* (1)	*COPING (1)*	
	PATIENCE (1)	*FRUSTRATING SOCIAL STUFF (1)*	
	Selfless (1)		

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